SANDMAN EXHIBIT M

		2003 CMI
5220303N	ACHIEVE REHAB AND NURSING	1.13
5926300N	ANDRUS ON HUDSON	0.90
1327301N	BAPTIST HOME OF BROOKLYN	1.10
5904317N	BAYBERRY NURSING HOME	1.10
5921301N	BETHEL NURSING AND REHABI	1.25
5905303N	BETHEL NURSING HOME COMPA	1.18
5931300N	BRANDYWINE NURSING HOME I	1.21
3557302N	CAMPBELL HALL REHABILITAT	1.33
5263000N	CATSKILL REGIONAL MEDICAL	1.13
5905308N	CEDAR MANOR NURSING & REH	1.16
5901304N	CORTLANDT HEALTHCARE LLC	1.27
1254300N	DELAWARE COUNTY COUNTRYSI	1.05
5904316N	DUMONT MASONIC HOME	1.19
1322302N	DUTCHESS CENTER FOR REHAB	1.11
1302305N	EDEN PARK HEALTH CARE CEN	1.16
3523302N	ELANT AT GOSHEN INC	1.32
3502304N	ELANT AT NEWBURGH INC	1.20
1327300N	FERNCLIFF NURSING HOME CO	1.13
5901302N	FIELD HOME-HOLY COMFORTER	1.27
1355300N	FISHKILL HEALTH RELATED C	1.24
4350305N	FRIEDWALD CENTER FOR REHA	1.38
3523303N	GLEN ARDEN INC	1.22
5904318N	GLEN ISLAND CARE CENTER	1.35
5501309N	GOLDEN HILL HEALTH CARE C	1.07
5957302N	HEBREW HOSPITAL HOME OF W	1.22
5904314N	HELEN AND MICHAEL SCHAFFE	1.36
4322300N	HELEN HAYES HOSPITAL RHCF	1.71
5907313N	HOME FOR AGED BLIND	1.15
1324301N	HUDSON HAVEN CARE CENTER	1.21
5556302N	HUDSON VALLEY REHABILITAT	1.12
1356302N	HYDE PARK NURSING HOME IN	1.20
5906300N	KING STREET HOME INC	1.15
1302306N	LUTHERAN CENTER AT POUGHK	1.21
5907316N	MICHAEL MALOTZ SKILLED NU	1.18
3561301N	MONTGOMERY NURSING HOME	1.21
1226300N	MOUNTAINSIDE RESIDENTIAL	1.12
5902316N	NATHAN MILLER CENTER FOR	1.11
5907310N	NEW SANS SOUCI NURSING HO	1.08
5501310N	NORTHEAST CENTER FOR SPEC	1.19
1327302N	NORTHERN DUTCHESS RESIDEN	1.20
4350304N	NORTHERN MANOR GERIATRIC	1.31
4353301N	NORTHERN METROPOLITAN RES	1.30
4321302N	NORTHERN RIVERVIEW HEALTH	1.38
4350302N	NYACK MANOR NURSING HOME	1.21
5951300N	NYS VETERANS HOME AT MONT	1.01
3501303N	PARK MANOR REHABILITATION	1.16
4353302N	PINE VALLEY CENTER FOR RE	1.18
5906303N	PORT CHESTER NURSING AND	1.18
3950301N	PUTNAM COMMONS RHCF	1.27
3951301N	PUTNAM NURSING AND REHABI	1.17

4329301N	RAMAPO MANOR CENTER FOR R	1.33
5907315N	REGENCY EXTENDED CARE CEN	1.13
1302307N	RIVER VALLEY CARE CENTER	1.19
1225000N	ROBINSON TERRACE	1.21
5262300N	ROSCOE COMMUNITY NURSING	1.17
5960302N	SALEM HILLS HEALTH CARE C	1.10
5909302N	SARAH NEUMAN CENTER FOR H	1.23
3529301N	SCHERVIER PAVILION	1.23
5902314N	SCHNURMACHER CENTER FOR R	1.28
5921302N	SKY VIEW REHABILITATION A	1.13
5966300N	SOMERS MANOR NURSING HOME	1.14
5910300N	SPRAIN BROOK MANOR N H	1.23
5925300N	ST CABRINI NURSING HOME I	1.20
5907314N	ST JOSEPHS HOSP NURSING H	1.36
3535001N	ST JOSEPHS PLACE	1.23
3501302N	ST TERESAS NURSING & REHA	1.47
5220301N	SULLIVAN COUNTY ADULT CAR	0.98
4353000N	SUMMIT PARK NURSING CARE	1.18
5904319N	SUTTON PARK CENTER FOR NU	1.13
5911301N	TARRYTOWN HALL NURSING HO	1.24
5957301N	TAYLOR CARE CENTER AT WES	1.25
5567300N	TEN BROECK COMMONS	1.19
1227000N	THE HOSPITAL SNF	1.15
5522302N	THE MOUNTAIN VIEW NURSING	1.10
3523301N	THE VALLEY VIEW CENTER FO	1.16
5903309N	THE WARTBURG HOME	1.23
4350301N	TOLSTOY FOUNDATION NURSIN	1.16
5968302N	TREETOPS REHABILITATION A	1.04
5904309N	UNITED HEBREW GERIATRIC C	0.95
5904315N	UNITED NURSING HOME FOR T	1.20
5905305N	VICTORIA HOME	1.02
1356300N	VICTORY LAKE NURSING CENT	1.22
5960300N	WATERVIEW HILLS NURSING C	1.25
5901305N	WEST LEDGE HEALTH CARE FA	1.22
5903310N	WESTCHESTER CENTER FOR RE	1.15
5957303N	WESTCHESTER MEADOWS	1.23
5902315N	WHITE PLAINS CENTER FOR N	1.13
1301301N	WINGATE AT ST FRANCIS LLC	1.33
1320301N	WINGATE OF DUTCHESS	1.21
5556301N	WINGATE OF ULSTER	1.24

SANDMAN EXHIBIT N

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335795	A. BUILDING _____ B. WING _____	05/12/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDRUS ON HUDSON	185 OLD BROADWAY HASTINGS ON HUDSON, NY 10706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164 SS=D	483.10(d)(3) FREE CHOICE The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview during the standard survey, the facility did not ensure that clinical and personal information for residents was secured in a manner to protect resident privacy and confidentiality. This was evident for 4 sampled residents (#1, #3, #12 and #24) in a sample of 26 residents and 11 out-of-sample residents. This resulted in no actual harm with the potential for more than minimum harm that is not	F 164		6/30/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 immediate jeopardy. Findings include, but are not limited to: On 5/10/05, between 1:10 PM and 1:25 PM, an unattended, locked medication cart was observed in the hallway on the third floor. During this time, a binder with medication records for half of the residents on the unit was noted on top of the medication cart, accessible to residents, visitors and staff members. Also located on top of the medication cart, at this time, was a Resident Census sheet identifying Residents #1, #3, #24 and 7 out-of-sample residents as having either a colostomy, ileostomy, diabetes or receiving dialysis. Additionally, handwritten notes indicating residents with infections and wounds, pertaining to Resident#12 and 4 out-of-sample residents, were also within plain view of passersby. In an interview with the Registered Nurse/medication nurse at 1:25 PM, she stated that she had inadvertently left these documents, with private resident information, unattended in a public area. In an interview with the RN Nurse Manager at 1:30PM on the same day, she confirmed that, for the sake of privacy, confidential resident information must be protected by always keeping it within the nurse's view and out of view of others. 415.3(d)(1)	F 164		
F 253 SS=B	483.15(h)(2) ENVIRONMENT The facility must provide housekeeping and maintenance services necessary to maintain a	F 253		6/30/05

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F 253	Continued From page 2 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews during the annual survey, the facility did not ensure that housekeeping services were provided to maintain resident care equipment, specifically wheelchairs and a walker, in a clean condition. This was evident for 7 sampled residents in a sample of 26 residents. (Residents #4, #7, #8, #10, #15, #20, and #21 and 6 out-of-sample residents. This resulted in the potential for minimal harm. Findings include: 1. During the observation of the lunch meal on 5/10/05 at 12:15 PM in the "C" dining room on the fifth floor, at least 7 residents were observed seated in wheelchairs that exhibited an excessive amount of dust or dirt on their wheels and/or frames. This included 3 sampled residents (Residents #4, #20 and #21 and 4 out-of-sample residents. Also immediately after completion of this meal 2 out-of-sample residents on the fifth floor were seen seated in soiled wheelchairs in the area directly facing the elevator. Interview with the Head of Housekeeping at 2:30 PM on 5/10/05 regarding these soiled wheelchairs revealed that wheelchairs are scheduled to be cleaned every three weeks. However, due to a lot of other responsibilities, the department is behind their cleaning schedule. 2. Additional observation on the third floor (on which only a few nonambulatory residents reside) revealed the following:	F 253		

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F 253	Continued From page 3 - On 5/10/05 at 2:00 PM, Resident #8's wheelchair was noted to be dusty and dirty. - Resident # 15's walker at 9:40 AM on 5/11/05 was noted to be dusty and dirty. 415.5(h)(2)	F 253		
F 281 SS=D	483.20(k)(3)(i) RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility did not ensure that the plan of care addressing residents nutritional/dietary needs were implemented as written. Specifically, observation of a nourishment pass and residents' accountability records did not consistently reflect that planned nourishments were offered and/or accepted and that thickened liquids were provided as prescribed. This was evident for 4 of 26 sampled residents (Residents #5, #17, #18, and #26). This resulted in the potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. Resident #17 has diagnoses which include diabetes mellitus. The resident's comprehensive plan of care dated 12/27/04 revealed that the resident has variable intake and has a planned goal to "Be free of observable signs and symptoms of hyperglycemia and hypoglycemia." To achieve this goal the resident's diet is to be	F 281		6/30/05

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F 281	Continued From page 4 implemented as ordered. A review of the Resident Care Flow Sheet (an accountability record and an extension of the comprehensive care plan) for the month of May 2005 showed that as a part of the resident's dietary regimen she was to be provided with 120 cc sugar free health shake twice daily, or at 2:00PM and 8:00 PM. This Flow Sheet also showed that the nourishment was inconsistently recorded as being given. There was no documentation to show that it was given 50 per cent of the time from 5/1/05 to 5/11/05, inclusive. In addition, observation of the Nourishment Pass on 5/12/05 at 2:00 PM revealed that the health shake was not available on the nourishment cart for the resident. This was confirmed by the certified nurse aide (CNA) who was passing the 2:00 PM nourishments. She had no explanation why it was not available. This was brought to the attention of the Registered Nurse manager of the unit who notified the dietary department of the missing nourishment. 2. Resident #5 has diagnoses which include dementia and osteoporosis. The resident's comprehensive plan of care for March 2005 revealed 2 planned goals for the resident to achieve weight stabilization and to consume greater than 75 per cent of her meals. According to physician's order sheet, the resident was prescribed health shake to be given three times daily at 10:00 AM, 2:00 PM, and 8:00 PM. The Resident Care Flow Sheets for the month of March 2005 was not revised to reflect this order and there is no recorded evidence that this supplement was given to the resident from	F 281		

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F 281	Continued From page 5 3/14/05 to 3/31/05. For the month of May 2005, documentation is missing on the Resident Care Flow Sheet which indicated that the health shake was not given 82 per cent of the time at 10:00 AM and 36 per cent of the time at 2:00 PM. On 5/12/05 at 2:00 PM the CNA passing the nourishments was asked if the resident's prescribed health shake was available. After checking the nourishment cart, the CNA stated that the resident's health shake was not available. She offered no explanation for this. The Registered Nurse manager of the unit notified the dietary department of the missing nourishment. On 5/12/05 at about 4:45 PM the registered dietitian stated that there is a computerized system in place to ensure that prescribed or planned nourishments are delivered to the units. She, however, offered no explanation as to why the above mentioned resident were not provided their planned nourishments. 3. Resident #18 has an order, dated 5/9/05, to be provided liquids thickened to a nectar-like consistency. The Registered Dietician documented in a 7/30/04 progress note that thickened liquids were necessary to prevent aspiration in this resident. During a meal observation on the fifth floor in the "D" dining room at 12:31 PM on 5/10/05, Resident #18 drank an 8 ounce glass full of un-thickened water, provided to her by a Certified Nurse's Aide (CNA). Later, during the same meal period, at 12:43 PM, the resident drank an additional 8 ounces of un-thickened water given to her by another CNA. The first CNA referred to above was interviewed	F 281		

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F 281	Continued From page 6 at 12:45 PM on 5/10/05. This CNA stated that the resident requires thickened liquids to prevent choking, but the resident "won't drink water at all with the thickener in it." The second CNA referred to above was interviewed at 1:10 PM, also on the same day. This CNA stated that, although she was aware that resident's liquids were supposed to be thickened, she gave plain water to the resident that day because the resident was very thirsty. Resident #18 was observed during the lunch meal at 12:15 PM on 5/12/05 drinking approximately 2 ounces of thickened water. The resident's plan of care did not indicate that she should be allowed un-thickened water. 415.11(c)(3)(i)	F 281		
F 327 SS=D	483.25(j) QUALITY OF CARE The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on interviews and record review during the annual survey, the facility staff did not fully evaluate and monitor the hydration status of each resident and implement planned and other appropriate interventions to maintain adequate hydration status. This was evident for 1 of 11 residents reviewed for nutritional concerns in a sample of 26 (Resident #26). This resulted in the potential for more than minimal harm that is not immediate jeopardy.	F 327		6/30/05

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F 327	Continued From page 7 Findings include: Resident #26 had diagnoses that included cerebral vascular accident and Parkinson's disease. The initial comprehensive care plan of 1/9/05 was revised on 3/18/05 to show that the resident had lost weight or was high risk for "inadequate intake sufficient for her needs." This was related to depression and cognitive impairment. The resident's hydration goal at that time was to consume 1500 cc of fluids daily. The planned interventions included the offering of 120 cc health shake three times daily, monitor intake, and assess appetite. (The most recent available laboratory report obtained 3/10/05 showed the resident's electrolytes and blood urea nitrogen levels to be within normal limits.) Nursing notes written on 4/27/05 at 9:00 PM revealed that the "Resident remains lethargic [with] decreased appetite." (No previous reference was made to lethargy in the nursing notes.) A similar note was written on 4/28/05 at 8:00 AM and 4/29/05 (time not noted). The 4/28/05 note showed that the "Resident remains lethargic [but] is responsive to verbal and tactile stimuli. Noted urine dark in color [with] strong pungent scent." The physician communication log revealed that he was notified of this condition. However, there is no documented evidence that he gave the staff any orders to change the resident's plan of care or evaluate the resident's condition. The resident's weight chart showed that her weight, which was being monitored weekly since 3/16/05 remained essentially stable until 5/2/05. The weight chart showed that her weight declined	F 327		

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F 327	Continued From page 8	F 327		

form 91 lbs. recorded on 4/27/05 to 81 lbs. on 5/2/05. This amount of loss in a one-week period is indicative of volume depletion per the assessment tool used by the facility (Multiple Data Set). However, there is no evidence of any measures to assess the resident's hydration status and of any attempts by the treatment team to have the resident increase her fluid intake orally after this weight loss was noted.

Since the description of the resident's condition described in the nursing note dated 4/29/05, and mentioned above, there is no further documentation of the resident's condition in the nursing notes until 5/6/05. Three entries were made on that date, which included the following findings:

- 7:00 PM "Resident awake & responsive but a bit weak & lethargic."
- 11:00 PM "Found by CNA to not breathing. No pulse felt...[Nurse initiated CPR [cardiopulmonary resuscitation]"
- 11:27 PM "Resident pronounced dead..."

A review of the Resident Care Flow Sheet (a document which is used by certified nurses aides to accounts for the care they provide to the resident and the resident's acceptance/refusal of the care) for the months of April 2005 and May 2005 revealed that the resident's fluid intake at meal times was recorded daily. An analysis by the surveyor of the recorded fluid intake data revealed the following daily averaged fluid intake:

- April 1, 2005 to April 27, 2005 - approximately 970 cc, (which included the nourishment given three times daily).
- April 28, 2005 to May 6, 2005 - approximately

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F 327	Continued From page 9 618 cc (the period after the nursing staff began to report that the resident was noted to be lethargic, have dark colored urine and lost 10 lbs. in one week.) This amount is 1030 cc or 59 per cent less than the resident's planned goal. The Flow Sheet for May 2005 did not include written instructions to inform the nurse aides that the resident is to continue on the dietary supplement initiated in March 2005 three times daily. There is also no documented evidence that the resident continued to receive this supplement in May 2005, which would have provided her an additional 288 cc of "free water" daily if offered. On 5/12/05 at about 3:15 PM, the primary care physician was interviewed about the care of the resident. He acknowledged that he was informed of the resident's condition described above, in particular the condition of the resident on 4/28/05. However, according to the physician, the resident had advanced directives, which stated no artificial feedings. As a result there was nothing more that could be done for the resident. Later that day at about 3:30 PM during an interview with the registered dietitian about the resident's hydration status, she was specifically asked if she was informed about the 10 lb. weight loss noted on 5/2/05 and if more could have been done to hydrate the resident. She stated that: 1) she was not informed of the weight loss; 2) the supplement could have been increased; and 3) a schedule could have been developed to hydrate the resident frequently throughout the day. In light of the poor fluid intake at meal times since at least 4/28/05 and the presence of dark colored urine on that date, the dietitian was also asked if	F 327		

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F 327	Continued From page 10 the adequacy of the resident's total daily fluid intake was determined by monitoring the amount of fluids consumed between meals. She stated that this is not a practice in the facility. She offered no other information to show how the facility staff routinely monitor and assess the total daily fluid intake of resident's at high risk for dehydration. Although the resident was not diagnosed to be dehydrated prior to her death, in light of the loss of 10 lbs. in on week (4/27/05 - 52/05) and the change in her medical condition noted, the above findings demonstrate that the resident was put at high risk for severe dehydration and complications associated with insufficient fluid intake secondary to facility staff not: 1) Assessing the resident's hydration status and the adequacy of the resident's total daily fluid intake on an ongoing basis; 2) consistently implementing the written plan of care by continuing to offer the resident the liquid nourishment started in March 2005; and 3) developing and implementing alternative measures to attempt to increase the resident's fluid intake orally. 10 NYCRR 415.12(j)	F 327		
F 426 SS=D	483.60(a) PHARMACY SERVICES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced	F 426		6/30/05

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	335795	A. BUILDING _____ B. WING _____	05/12/2005

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F 426	Continued From page 11 by: Based on record review and staff interview, the facility did not ensure the provision of pharmacy services to assure the accurate acquiring and timely administering of all drugs to meet the needs of each resident. This was evident for 1 of 26 sampled residents. (Resident # 24) This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings are: Resident # 24 has diagnoses including diabetes mellitis, bilateral below knee amputation, and end stage renal disease. Review of the resident's December 2004 physician's order sheet revealed a 12/21/04 order for "Oxycontin 10 mg by mouth every 12 hours for pain." However, review of the Medication Administration Record (MAR) revealed that on three dates, 12/30/04 at 9PM, 12/31/04 at 9PM, and 01/01/05 at 9AM the Oxycontin was not administered because it was not available. Review of the facility's contract with the vendor pharmacy indicated that medications are to be made available twenty-four hours per day, seven days a week. In an interview with the Licensed Practical Nurse(LPN) on 05/12/05 at 3:30PM, she stated that when she noticed that the resident's medication was not available, she called the pharmacy. She also stated that she contacted the physician on 12/30/04 in order for him to send a script to the pharmacy for Oxycontin which is a	F 426		

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F 426	Continued From page 12 controlled medication. The LPN was unable to explain why the medication did not arrive at the facility for the resident on 12/30/04. In addition, interview with the Medical Director on 05/12/05 at 5:00PM indicated that he could not recall if he was contacted by the facility nurse in order for him to call the pharmacy to deliver the resident's medication to the facility. An additional interview with the Director of Nursing (DON) on 05/12/05 revealed that she was not informed of the unavailability of Oxycontin for this resident on the dates 12/30/04, 12/31/04 and 01/01/05 until informed by the surveyor during survey. The DON also stated that the medication nurse should have informed the nursing supervisor that the medication was not available so that an investigation would be initiated. The DON provided no evidence that this was done. 415.18(a)	F 426		
F 441 SS=E	483.65(a)(1)-(3) INFECTION CONTROL The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observations, medical record reviews, and interviews with staff during the annual survey,	F 441		6/30/05

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F 441	Continued From page 13 the nursing and medical staff did not, in all cases, ensure that residents were offered or received the pneumococcal vaccine in accordance with the facility's established infection control program to minimize the potential for the development and spread of pneumococcal infections. This was evident for 5 of 26 sampled residents reviewed for the pneumococcal vaccination (Residents # 2, #4, #8, #17, and #22). This resulted in no actual harm with potential for more than minimal harm. Findings include: The facility's policy and procedures for "Prevention of Pneumonia" states that based on Centers for Disease control guidelines, pneumococcal vaccine will be offered to all residents over 65 years of age not having received the vaccine within the last 5 years. The review of medical records of residents residing on 3 of 4 units revealed that this policy was not implemented for the following residents: 1. THIRD FLOOR During review of Resident # 8's medical record, it was determined that the pneumococcal vaccine was not offered or administered to the resident. Upon interview at 11 AM on 5/10/05 with the charge nurse (a Registered Nurse) on that floor, she could not find any record of the pneumococcal vaccine being offered to or refused by the resident. 2. FOURTH FLOOR Review of immunization records for Residents #2	F 441		

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F 441	Continued From page 14 and #22 at 11:00 AM on 5/12/05 revealed no evidence that pneumococcal vaccine had been offered to, administered to, or declined by these residents during the past 5 years. In an interview with the Nurse Manager, a Registered Nurse, at 12:00 PM on 5/12/05, she stated that no other records could be located to indicate that these residents had received the vaccine. She further stated that it had to be assumed that the residents did not receive the vaccinations. 3. FIFTH FLOOR a. Review of the immunization record for Resident # 4 revealed no evidence that a pneumococcal vaccine had been offered, administered to, or declined by this resident. During an interview on 05/10/05 at 1:46 PM, the Registered Nurse/nurse manager reported that no documentation was available to show that the pneumococcal vaccine was received or refused by the resident. b. Review of the Resident #17 current physician order sheet revealed that the resident was to be administered a 0.5ml x1 dose of the pneumococcal vaccine if the resident had never received or was unaware of receiving the vaccine more than 5 years ago. Upon interview with the nurse manger on 05/12/05 in the afternoon, she failed to provide the surveyor with any documentation to show that the resident was administered or refused the pneumococcal vaccine. 10 NYCRR 415.19(a)(1),(b)	F 441		
F 444	483.65(b)(3) INFECTION CONTROL	F 444		6/30/05

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F 444 SS=D	Continued From page 15 The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observations, and interviews during the standard survey, the facility did not ensure that nursing staff washed their hands between contact with residents and after being soiled as indicated by current standards of practice to prevent the potential spread of infections. This was evident while staff provided care for 2 sampled residents (#7 and #17) and 2 out-of-sample residents. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. During a meal observation in the fifth floor "D" dining room at 12:17 PM on 5/10/05, 2 Certified Nursing Aides (CNA #1 and CNA #2) were observed. Each CNA grasped one of the resident's upper arms and thighs to lift her in her chair. CNA #1, without washing her hands, immediately proceeded to pour a cup of water from a common pitcher and feed the water to this same resident. Then, at 12:19 PM, CNA #1, still not having washed her hands, proceeded to set-up food trays for Resident #17 and an out-of-sample resident. At this same time, CNA #2 applied a bib for Resident #7, served, and set-up this resident's food tray, without washing her hands.	F 444		

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F 444	Continued From page 16 2. During a medication pass observation on the fifth floor at 9:10AM on 5/11/05, the Licensed Practical Nurse medication nurse was observed to pat her hair and scratch her head without washing her hands. This LPN then opened the medication cart, touched numerous medication packages, spooned out applesauce from a multiple use container, mixed medications with the applesauce, and fed them to a non-sampled resident, without washing her hands. Next, the LPN poured water from a common pitcher, mixed it with a thickening agent, and fed it to the resident. Immediately afterwards, the LPN was observed to touch her eyeglasses, swipe her nose, scratch her head, pat the lap and bare knees of another non-sampled resident. Again, without washing her hands, the LPN proceeded to hold the shoulder of this non-sampled resident while listening to her heartbeat and then administering crushed medications. In an interview with the LPN at 9:25AM on the same day, she stated that she was aware of proper hand hygiene practices but did not realize she was touching herself and was not conscious of touching the residents while preparing and administering medications. 415.19(b)(4)	F 444		
F 514 SS=D	483.75(l)(1) ADMINISTRATION The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and	F 514		6/30/05

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F 514	Continued From page 17 systematically organized. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility did not ensure that the clinical record of each resident was complete. Specifically, the clinical record did not reflect discussion between a resident's health care Proxy agent and the primary care physician concerning life-threatening issues related to insufficient fluid intake and changes in physical status. This was evident for 1 of 26 sampled residents (Resident #26). Findings include: Resident #26 had diagnoses, which included cerebral vascular accident and Parkinson's disease. A review of the resident's clinical record, including the MDS dated 3/14/05, weight record and a dietary note written in March 2005, revealed that the resident experienced a significant decline in her cognitive status and activities of daily living, and experienced an 8 per cent weight loss in 2 months between her admission to the facility on 1/5/05 and 3/16/05. The clinical record also contained an advanced directive, Health Care Proxy (HCP), signed by the resident. This document stated that the resident appointed an agent to make any and all health care decisions for her, except to the extent that the resident states otherwise. It also stated that the agent knows the resident's wishes regarding artificial nutrition and hydration and if there is no hope for recovery, no artificial feeding should be provided.	F 514		

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F 514	Continued From page 18 A review of the Resident Care Flow Sheet for the month of April 2005 and May 2005 revealed that the nursing staff recorded the resident's daily fluid intake. An analysis of the recorded data by the surveyor revealed that the resident's daily fluid intake averaged 618 cc form April 28, 2005 - May 6, 2005. However, per the comprehensive care plan dated 3/18/05, one of the goals for the resident was to consume 1500 cc of fluids daily. Additional documentation in the resident's clinical record revealed a nursing note written on 4/27/05 at 9:00 PM which stated that the "Resident remains lethargic [with] decreased appetite." (No previous reference was made to lethargy in the nursing notes.) A similar note was written on 4/28/05 at 8:00 AM and 4/29/05 (time not noted). The 4/28/05 note showed that the "Resident remains lethargic [but] is responsive to verbal and tactile stimuli. Noted urine dark in color [with] strong pungent scent." There was no further documentation of the resident's condition in the nursing notes until 5/6/05. Three entries were made on that date, which included the following findings: - 7:00 PM "Resident awake & responsive but a bit weak & lethargic. - 11:00 PM "Found by CNA to not breathing. No pulse felt..." - 11:27 PM "Resident pronounced dead..." A review of the physician's note sheets and nursing notes revealed no response by the physician to address the resident's condition described from 4/27/05 to 5/6/05 prior to being pronounced dead. Also, there is no documented evidence in the clinical record that the care	F 514		

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F 514	Continued From page 19 necessary to address the resident's hydration status and general physical decline in the context of the limitations of the resident's advanced directives were discussed with the HCP agent between 4/27/05 and 5/6/05. On 5/12/05 at about 3:15 PM the primary care physician was interviewed via telephone about the care of the resident. He acknowledged that he was informed of the resident's condition described above, including the condition of the resident on 4/28/05. However, the resident had advanced directives, which stated no artificial feedings. As a result, there was nothing more that could be done for the resident. He also stated that he did discuss the resident's condition with the HCP agent but he could not recall the specific date. Later on 5/12/05 at about 4:45 PM, the HCP agent was interviewed about her communication with the resident's physician. She stated that she visited the resident in the facility on 4/30/05 and the nursing staff informed her of the resident's poor appetite. However, she did not have any conversation or contact with the resident's physician since the resident's admission to the facility. (The HCP agent also stated that she would not have given permission for artificial hydration.) Due to no documentation in the resident's clinical record about communication with the HCP agent, it cannot be determined if the resident's care in the context of the limitations of her advanced directives were appropriate to address her declining condition from at least 4/27/08 to the time of her death on 5/6/05. Specifically, there is no documentation in the record to reflect the	F 514		

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F 514	Continued From page 20 information about the resident's condition that the physician allegedly communicated to the HCP agent and her (the agent's) response to this information. Also, due to lack of documentation, the physician's contact or lack of contact with the HCP agent cannot be validated. 415.22(a)(1-4)	F 514		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 000	INITIAL COMMENTS The facility must meet the applicable provisions of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) requirements for Long Term Care Facilities.	K 000		
K 025 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Chapter 8.3.6 Penetrations and Miscellaneous Openings in Floors and Smoke Barriers. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.	K 025		6/30/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025	Continued From page 1 b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. Based on observation and interview the facility did not ensure that all smoke barriers were constructed to provide at least a ½ hour fire resistance rating and constructed in accordance with 8.3. This was evidenced by the presence of unsealed penetrations, passing completely through approximately 10 of 17 smoke barrier walls inspected, located on four of six floors reviewed. This resulted in no actual harm with potential for minimal harm that is not immediate jeopardy. Findings are: On 05/10/05 penetrations were observed in the following locations (not all-inclusive): 1. The following barrier walls located along the electrical closets had penetrations present ranging from 2"- 5". -all four barriers on the fifth floor, fourth floor A and C wings, and on the third floor A, B, and C wings. 2. The barrier located by the elevator on the lower	K 025		

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K 025	Continued From page 2 level had concrete filling three penetrations through a gypsum board wall in lieu of the required fire stop material. Upon interview on 05/10/05 at 11:50 am, the Director of Building Facilities stated that the company conducting the fire-stopping will be back and that he would add these areas to the list to be completed. 2000 NFPA 101 LSC: 8.3, 19.1.6.3, 19.1.6.4, 19.3.7.3, 19.3.7.5 10 NYCRR 711.2 NYCRR 415.29	K 025		
K 047 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: 2000 NFPA 101 LSC Chapter 19.2.10 Marking of Means of Egress. Chapter 19.2.10.1- Means of egress shall have signs in accordance with Section 7.10. 2000 NFPA 101 LSC Chapter 7.10.1.2 - Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. Based on observation and interview the facility did not ensure that exit and exit directional signs	K 047		6/30/05

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 047	Continued From page 3 were provided and continuously illuminated to direct people in case of a fire. This was observed on five of six floors. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings are: On 05/10/05 between 9 am and 11:30 am the following but not limited to exit signs were observed missing/not functioning: 1. The following areas were observed missing exit signs leading to the rotunda: 5th floor a & d wings, 4th floor all wings, 3rd floor all wings, 2nd floor all wings and by the stairwell door by the beauty parlor. 2. Exit signs were not illuminated on the fifth floor b and c wings leading to the rotunda. Interview with the Director of Building Facilities at approximately 10 am on 5/10/05 revealed that the facility would install new exits signs which were missing and replace the light bulbs on the ones that were burnt out. He further indicated that they would replace the older exit signs on several floors with new ones. 2000 NFPA 101 LSC; 19.2.10, 7.10 10NYCRR 711.2 NYCRR 415.29	K 047		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.	K 050		6/30/05

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335795	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/12/2005

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ANDRUS ON HUDSON	185 OLD BROADWAY HASTINGS ON HUDSON, NY 10706

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K 050	Continued From page 4 The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: 19.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined in the fire safety plan. Based on observation and interviews the facility did not ensure that dietary staff were familiar with the following fire safety procedures: -use of the code phrase -the correct usage of fire extinguishers located in the kitchen. This resulted in no actual harm with potential for more than minimal harm that is not immediate	K 050		

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K 050	Continued From page 5 jeopardy. Findings are: On 05/11/05 at approximately 11 am while conducting fire questions, dietary staff were questioned on the procedure to follow upon discovering a fire and on the use of fire extinguishers in the kitchen. The following was observed: 1. Three of five dietary staff did not know the code phrase, "Dr. Red" and did not know the use of the phrase to ensure the transmission of an alarm when the discoverer must immediately go to the aid of an endangered person. 2. Three staff members were questioned about the correct fire extinguisher to use in a grease fire. All three staff members stated that they would use the ABC Fire Extinguisher in lieu of the required 'K' extinguisher. Interview with the Director of Building Facilities at that time reveal that he would conduct an Inservice of all dietary staff on the correct fire procedures and the correct usage of the Type K Fire Extinguishers located in the kitchen. 2000 NFPA 101 LSC; 19 NYCRR 415.29	K 050		
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by	K 051		6/30/05

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K 051	Continued From page 6 manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and interview the facility did not ensure that fire alarm system was maintained according to NFPA 72 in that upon activation, five (5) of approximately 25 fire bells either did not operate or sounded the incorrect fire location code. This was evidenced on five of six floors observed. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy: Findings are: On 05/11/05 at 1:45 pm, during a test of the fire	K 051		

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K 051	Continued From page 7 alarm system, the following but not limited fire bells did not operate properly: four bells on the second floor and 2 bells on the first floor. Upon interview at 1:55 pm, the Director of Building Facilities stated that he did not know why these alarms were malfunctioning. Further investigation at that time revealed that several bells had items attached to the inside of the bell to muffle the sounds. He further indicated that he would have the alarm company inspect all bells throughout the facility. 1999 NFPA 72; 7 2000 LSC NFPA 101 19.3.4.4, 9.6.3.8 10 NYCRR 415.29 (a)(1) NYCRR 711.2 (a)(1)	K 051		
K 064 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: 2000 NFPA 101 19.3.5.6 Extinguishment Requirements- Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 2000 NFPA 101 Chapter 9.7.4.1 Manual Extinguishing Equipment - Where required by the provisions of another section of this code, portable fire extinguishers shall be installed, inspected and maintained in accordance with	K 064		6/30/05

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K 064	Continued From page 8 NFPA 10, Standard for Portable Fire Extinguishers. 1998 NFPA 10 Standard for Portable Fire Extinguishers- Chapter 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. 4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d) * Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or 'hefting' (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position (h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (i) HMIS label in place Based on observation and interview, the facility did not inspect all portable fire extinguishers throughout the facility on a monthly basis. This was noted on two of six floors inspected. This resulted in no actual harm with the potential for minimal harm that is not immediate jeopardy. Findings are:	K 064		

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K 064	Continued From page 9 On 05/10/05 between 8:30 am and 3:00 pm, it was observed that the following fire extinguishers (not all inclusive) were not inspected on a monthly basis: two on the Solarium floor, seven fire extinguishers located on the lower level service area near or in the electrical switch room. Interview with the Director of Building Facilities at approximately 10:30 am revealed that the fire extinguishers found were back up extinguishers and that they would be checked and added to the monthly inspection list. 1998 NFPA 10; 4-3 2000 NFPA 101 LSC; 19.3.5.6, 9.7.4.1 NYCRR 415.29	K 064		
K 067 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: 2000 NFPA 101 Chapter 19.5.2 Heating, Ventilating, and Air Conditioning. 19.5.2.1 Heating, ventilating, and air conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer¿s specifications. 2000 NFPA 101 Chapter 9.2 HEATING, VENTILATING, AND AIR CONDITIONING	K 067		6/30/05

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 067	Continued From page 10 9.2.1 Air Conditioning, Heating, Ventilating Ductwork, and Related Equipment. Air conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. 1999 NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilation Systems Chapter 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. Based on observation, interview, and record review it was determined that the facility did not ensure that all fire dampers, installed in connection with the ventilation system/air conditioning equipment, are exercised every four years, in accordance with NFPA 90A, standard for the installation of air conditioning. This resulted in no actual harm with the potential for minimal harm that is not immediate jeopardy. Findings are: On 05/10/05 at approximately 2 pm, while reviewing records with the Director of Building Facilities, it was observed that there were no records of dampers being exercised or	K 067		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 067	Continued From page 11 maintained. Interview with the Director of Building Facilities at that time revealed that he did not know if the dampers were exercised or maintained. He further indicated that he would hire an outside company to service all dampers in the building. 2000 NFPA 101 LSC; 19.5.2, 9.2.1 1999 NFPA 90A; 3-4.7 10 NYCRR 711.2 (a)(1)	K 067		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
335795	A. Building B. Wing	6/30/2005

Name of Facility	Street Address, City, State, Zip Code
ANDRUS ON HUDSON	185 OLD BROADWAY HASTINGS ON HUDSON, NY 10706

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0164 Reg. # 483.10(d)(3) LSC	Correction Completed 06/30/2005	ID Prefix F0253 Reg. # 483.15(h)(2) LSC	Correction Completed 06/30/2005	ID Prefix F0281 Reg. # 483.20(k)(3)(i) LSC	Correction Completed 06/30/2005
ID Prefix F0327 Reg. # 483.25(j) LSC	Correction Completed 06/30/2005	ID Prefix F0426 Reg. # 483.60(a) LSC	Correction Completed 06/30/2005	ID Prefix F0441 Reg. # 483.65(a)(1)-(3) LSC	Correction Completed 06/30/2005
ID Prefix F0444 Reg. # 483.65(b)(3) LSC	Correction Completed 06/30/2005	ID Prefix F0514 Reg. # 483.75(l)(1) LSC	Correction Completed 06/30/2005	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/12/2005	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

ublic reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and aintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information cluding suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork eduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
335795	A. Building B. Wing 01 - MAIN BUILDING 01	6/30/2005

Name of Facility	Street Address, City, State, Zip Code
ANDRUS ON HUDSON	185 OLD BROADWAY HASTINGS ON HUDSON, NY 10706

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'4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0047	Correction Completed 06/30/2005	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 06/30/2005	ID Prefix Reg. # NFPA 101 LSC K0051	Correction Completed 06/30/2005
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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eviewed By 'tate Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
eviewed By MS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

›llowup to Survey Completed on: 5/12/2005	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO